

**COMPLETE, PRINT & RETURN THIS FORM**  
**SANTA MONICA HIGH SCHOOL STUDENT EMERGENCY CARD 2011-12**

Please complete all parts of this form and sign below. If your child becomes ill or is injured while on this school-approved trip, it is important that information on this card is accurate and complete. Information will be kept confidential.

Students Full Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_  
 Male  Female ID# \_\_\_\_\_ Grade \_\_\_\_\_ / / ( )

Student's Birth Date \_\_\_\_\_ Students Cell Phone (if taking) ( )

Father's Name (Or Guardian) \_\_\_\_\_ Father's WORK Phone \_\_\_\_\_ Father's CELL Phone \_\_\_\_\_

( ) ( )

Mother's Name (Or Guardian) \_\_\_\_\_ Mother's WORK Phone \_\_\_\_\_ Mother's CELL Phone \_\_\_\_\_

STUDENT LIVES WITH:  Mother  Father  Both  Guardian  Joint Custody

NAME of Health Insurance Carrier \_\_\_\_\_ Subscriber \_\_\_\_\_

Group # \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_ MediCal# \_\_\_\_\_

Identify any health problems that your child has or may experience while away:

LAST TETANUS BOOSTER (month/year): \_\_\_\_\_ / \_\_\_\_\_ LAST MEDICAL EXAM (month/year): \_\_\_\_\_ / \_\_\_\_\_

AUTHORIZATION FOR MEDICATION – Medication will not be given without your signature. If left blank or crossed out, medication will NOT be made available to your child. I hereby request and authorize that the Chaperones make available the following medication(s) as directed by the SMMUSD physician consultant:

Medication (cross out if you do NOT want given)	Dose (same for either Meds)	Frequency	Parent Signature - Required
Acetaminophen (Tylenol) 325mg tablet	1 tablet if student weighs less than 100 pounds	By mouth Every 4-6 hours	x
Ibuprofen (Motrin, Advil) 200mg tablet	2 tablets if student weighs more than 100 pounds		x

**ALLERGIES:** Describe completely any allergies and/or reactions your child may have to any **FOOD** or **MEDICATIONS**. **IF YOUR CHILD HAS ANY LIFE THREATENING REACTIONS**, please make sure instructions are included and treatment described (include food and medicine allergies):

Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**IN THE EVENT OF A MEDICAL EMERGENCY**, if I cannot be reached, I hereby give consent for my child to be transported to an Emergency facility and to receive necessary medical attention from a licensed physician, practitioner or dentist.

**SIGNATURE** of parent or legal guardian \_\_\_\_\_ **Date** \_\_\_\_\_

**PRINT** name of parent or legal guardian \_\_\_\_\_

**EMERGENCY CONTACTS:** If parents cannot be reached, the school is ONLY authorized to release your child to the below persons. Please supply the names of **AT LEAST 2** persons who will know how to reach you in case of an emergency.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Address \_\_\_\_\_ Phone (day/eves) \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_